Department of Human Services
Bureau of Human Service Licensing
LICENSING INSPECTION SUMMARY PUBLIC

May 11, 2026

[redacted], CHIEF OPERATIONS OFFICER
LANDIS HOMES RETIREMENT COMMUNITY
1001 EAST OREGON ROAD
LITITZ, PA, 17543

RE: LANDIS HOMES RETIREMENT COMMUNITY
1001 EAST OREGON ROAD
LITITZ, PA, 17543
LICENSE/COC#: 32177

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/18/2026, 03/19/2026 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *LANDIS HOMES RETIREMENT COMMUNITY* **License #**: *32177* **License Expiration**: *06/03/2026*

Address: *1001 EAST OREGON ROAD, LITITZ, PA 17543*

County: *LANCASTER* **Region**: *CENTRAL*

Administrator

Name: [redacted] **Phone**: [redacted] **Email**: [redacted]

Legal Entity

Name: *LANDIS HOMES RETIREMENT COMMUNITY*

Address: *1001 EAST OREGON ROAD, LITITZ, PA, 17543*

Phone: [redacted] **Email**: [redacted]

Certificate(s) of Occupancy

Type: *I-2* **Date**: *12/26/2006* **Issued By**: *Manheim Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *104* **Waking Staff**: *78*

Inspection Information

Type: *Full* **Notice**: *Unannounced* **BHA Docket #**:

Reason: *Renewal* **Exit Conference Date**: *03/19/2026*

Inspection Dates and Department Representative

03/18/2026 - On-Site: [redacted]

03/19/2026 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *124* **Residents Served**: *88*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Lititz* **Capacity**: *16* **Residents Served**: *16*

Hospice

Current Residents: *2*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *88*

Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *16* **Have Physical Disability**: *0*

Inspections / Reviews

03/18/2026 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/17/2026*

04/16/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *05/08/2026*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/22/2026*

Inspections / Reviews *(continued)*

04/17/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *05/08/2026*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *05/11/2026*

05/11/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *05/08/2026*

Reviewer: [redacted] **Follow Up Type:** *Not Required*

18 - Compliance With Laws

1. Requirements

2600.
18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

The Care Facility Carbon Monoxide Alarms Standards Act, enacted 9/23/16, requires the battery of battery-operated carbon monoxide alarms be labeled with the date of installation and replaced at least once annually. On 3/18/26, the carbon monoxide alarm in the Dogwood kitchen had a label indicating to replace the battery by 3/2025. The carbon monoxide alarm in the Birch kitchen did not have a label indicating the date that the battery had been installed

Plan of Correction ***Accept ([redacted] - 04/17/2026)***

All Carbon Monoxide detectors were being routinely checked and batteries changed per the electronic work order system.
On March 18, 2026, the batteries in the carbon monoxide alarms located in the Dogwood kitchen and Birch kitchen were replaced. Each carbon monoxide alarm battery was labeled with the date of installation at the time of replacement. The alarms were tested at the time of battery replacement to ensure proper working condition.
Effective March 18, 2026, facility implemented a standardized procedure requiring all battery-operated carbon monoxide alarms to have batteries not only replaced annually but labeled with the installation date at the time of replacement. On March 18, 2026, Facilities Staff were re-educated on the Carbon Monoxide Alarms Standards Act requirements and facility procedures related to alarm maintenance and labeling.
Beginning May 1, 2026, The Facilities Manager or designee will conduct and document quarterly audits of all carbon monoxide alarms to ensure batteries are properly labeled with installation dates and replaced annually as required. Audit documentation will be maintained for review during licensing inspections.

Licensee's Proposed Overall Completion Date: *05/01/2026*

Implemented ([redacted] - 05/11/2026)

81b - Resident Personal Equipment

2. Requirements

2600.
81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

On 3/19/26 at 3:11 PM, Resident #1's bed was had an uncovered enabler device with an opening measuring 10" wide x 7" high, creating a potential entrapment hazard.

Plan of Correction ***Accept ([redacted] - 04/17/2026)***

On March 19, 2026, the uncovered enabler device on Resident #1's bed was immediately corrected. Facility approved enabler was added. Resident #1 was not harmed.
Effective April 15, 2026, the facility implemented a standardized bed safety inspection process requiring all resident beds, including enabler devices and accessories, to be inspected for proper installation and potential hazards. On April 2, 2026, at the All-Staff Meeting, nursing and caregiving staff were reeducated on identifying entrapment risks and the requirement that resident equipment remain safe, in good repair, and free from hazards. Any identified

81b Resident Personal Equipment (continued)

concerns are now reported immediately to the Administrator or Maintenance for corrective action.
In addition, Home Rules have been adjusted to only permit DHS approved bed enablers, effective 30 days from notice of home rule change. Which is May 15, 2026.
Beginning May 1, 2026, the Administrative LPN will conduct and document monthly audits of resident beds and related equipment to ensure compliance with safety requirements and absence of entrapment hazards. Results of audits will be maintained for review during licensing inspections.

Licensee's Proposed Overall Completion Date: *05/01/2026*

Implemented ([redacted] - 05/11/2026)

183b - Meds and Syringes Locked

3. Requirements

2600.
183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

On 3/18/26 at 12:04 PM, a tube of zinc oxide ointment 25% skin protectant was unlocked, unattended, and accessible in resident room #44.

Plan of Correction ***Accept ([redacted] - 04/17/2026)***

On March 18, 2026, the zinc oxide ointment located in Resident Room #4 was immediately secured in a locked medication storage area. The room was inspected at the time of discovery to ensure there were no additional medications left unlocked or accessible. Resident safety was maintained at all times, and no harm occurred.
Residents are educated monthly at Resident Council of the importance of not bringing any medications or lotions without informing nursing staff. The most recent dates were March 12, 2026, and April 9, 2026. Resident purchased the ointment at an outside store and failed to report it to nursing.
By April 30, 2026, all caregiving staff will be re educated on medication storage requirements under 55 Pa. Code §2600.183, including the requirement that prescription, OTC, and topical medications must be kept locked at all times when not in use, including medications stored in resident rooms. Clear reminders were provided that unattended medications may not be left accessible. Supervisory staff and household leads were instructed to reinforce expectations during shifts.
Beginning May 1, 2026, The Household Leads or designee will conduct and document monthly audits of resident rooms and medication storage areas to ensure compliance with locked medication requirements. Clinical Care Coordinator will review audits upon completion. Any identified concerns will be addressed immediately, and audit results will be maintained for review during licensing inspections.

Licensee's Proposed Overall Completion Date: *05/01/2026*

Implemented ([redacted] - 05/11/2026)

184a - Resident's Meds Labeled

4. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

184a - Resident's Meds Labeled *(continued)*

4. The prescribed dosage and instructions for administration.

Description of Violation

Resident #1 is prescribed Biofreeze roll-on gel 4% apply topically to right knee twice daily for right knee pain and advanced osteoarthritis. The pharmacy label for the Biofreeze roll-on gel 4% indicated to apply topically to right knee three times daily for right knee pain and advanced osteoarthritis.

Plan of Correction ***Accept ([redacted] - 04/17/2026)***

On March 18, 2026, the Biofreeze roll on gel 4% prescribed for Resident #1 was removed from use upon identification of the labeling discrepancy. Although there was a sticker directing staff to review the MAR due to the order change, the prescribing provider and pharmacy were notified, and a corrected pharmacy label matching the current physician order was obtained on March 19, 2026. The medication was relabeled appropriately prior to being returned to service. Resident #1's medication administration followed the physician's order, and no harm occurred.
Effective March 20, 2026, the facility educated the nursing staff on the medication reconciliation process requiring nursing staff to verify that pharmacy labels accurately reflect current physician orders prior to medication administration. By April 30, 2026, all nursing staff will be re educated on medication labeling requirements under 55 Pa. Code §2600.184 and the importance of immediately addressing discrepancies by contacting the pharmacy and provider. Medications with discrepancies are now held until corrected labeling is obtained.
Beginning May 1, 2026, the Clinical Administrative LPN will conduct and document monthly audits of resident medication labels compared against physician orders to ensure accuracy and compliance. Clinical Care Coordinator will review all audits upon completion. Any discrepancies identified will be corrected immediately and documented. Audit records will be maintained for review during licensing inspections.

Licensee's Proposed Overall Completion Date: *05/01/2026*

Implemented ([redacted] - 05/11/2026)

185a - Implement Storage Procedures

5. Requirements

2600.
185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

Resident #3 was prescribed blood glucose monitoring three times a day call MD if BS <60 or >400; hold Humalog for BS < 150. Give with meal Freestyle Libre sensor for blood sugar before meals. The blood glucose readings on the Freestyle Libre reader used for Resident #3 did not match the numbers transcribed on the resident's March 2026 Medication Administration Record on the following dates:
- Libre reading on 3/6/26 at 12:08 PM was 313 - the number documented in the MAR on 3/6/26 at midday reads 331.
- Libre reading on 3/8/26 at 1:03 PM was 73 - the number documented in the MAR on 3/8/26 at midday reads 76.
- Libre reading on 3/9/26 at 9:11 AM was 192 - the number documented in the MAR on 3/9/26 in the morning reads 201.
- Libre reading on 3/9/26 at 11:03 AM was 304 - the number documented in the MAR on 3/9/26 at midday reads 301.
- There is no reading documented in the MAR on 3/11/26 at midday. On 3/11/26, there were Libre readings of 186 at 11:36 AM and 182 at 11:45AM.

185a - Implement Storage Procedures (continued)

Plan of Correction ***Accept ([redacted] - 04/17/2026)***

On March 18, 2026, nursing leadership reviewed the Freestyle Libre reader data and MAR documentation for Resident #3. On April 2, 2026, staff responsible for glucose monitoring and documentation were educated regarding the discrepancies. The resident's blood glucose monitoring process was clarified to ensure that values are directly and accurately documented from the Freestyle Libre reader onto the MAR at the time of reading. Resident #3 experienced no adverse outcome related to the documentation discrepancies.

By April 30, 2026, the facility reinforced and clarified policy and procedures (Continuous Glucose Monitors) for the safe use, access, and documentation of blood glucose monitoring equipment. Nursing and medication administration staff were reeducated on the requirement that blood glucose values must be directly transcribed from the monitoring device to the MAR without estimation, rounding, or delay. On April 2, 2026 at the All Staff meeting and on April 13, 2026 via email notification staff were instructed to document all required readings at the scheduled times as ordered. A standardized procedure was implemented for verifying accuracy of documentation when electronic monitoring devices are used.

Beginning May 1, 2026, the Administrative LPN will conduct and document monthly audits comparing blood glucose monitoring device readings with MAR documentation for residents requiring glucose monitoring. Findings will be reported to Clinical Care Coordinator. Any discrepancies identified will be addressed immediately through corrective action and staff re education. Monitoring records will be maintained for review during licensing inspections.

Licensee's Proposed Overall Completion Date: *05/01/2026*

Implemented ([redacted] - 05/11/2026)

187b - Date/Time of Medication Admin.

6. Requirements

2600.
187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident #1 was prescribed O2 apply via nasal cannula to keep POX greater than 90% every shift for SOB. The resident's March 2026 Medication Administration Record (MAR) did not include the initials of the staff who administered the oxygen on 3/9/26 in the evening.

Resident #4 was ordered to receive moisturizer – apply house lotion daily to legs at bedtime. The resident's March 2026 MAR did not include the initials of the staff person who applied the moisturizer on 3/5/26.

Resident #4 was ordered to elevate legs for 60 mins daily in recliner in afternoon one time a day. The resident's March 2026 MAR did not include the initials of the staff person who provided this treatment on 3/13/26 at 13:00.

Resident #5 was ordered right lower extremity: cleanse area with wound cleanser, apply thin layer of Vaseline, cover with non-adherent dressing, cling wrap than COBAN. Change dressing daily and PRN for soiling/loosening every evening shift for wound care nurse only and Tubigrip socks to bilateral lower legs in AM and off in PM every evening shift for edema. The resident's March 2026 MAR did not include the initials of the staff person who administered the

187b - Date/Time of Medication Admin. (continued)

wound care and Tubigrip socks on 3/5/26, 3/7/26, and 3/11/26.

Plan of Correction ***Accept ([redacted] - 04/17/2026)***

On March 18, 2026, nursing leadership reviewed the MARs for Residents #1, #4, and #5 with the staff involved. All staff were educated on the requirement to document all medication administrations and treatments at the time they are provided, including dating, timing, and initialing the MAR at the staff meeting on April 2, 2026. A review of resident care confirmed that the ordered medications and treatments had been provided as prescribed and that no resident harm occurred.

Effective April 15, 2026, the facility reviewed medication and treatment documentation policy and procedures (Assistance with Medication Administration) to ensure compliance with 55 Pa. Code §2600.187. Nursing and direct care staff were reeducated on the requirement that all medications, oxygen administration, and treatments must be documented on the MAR immediately at the time of administration, including staff initials. Staff were instructed to reinforce expectations during shifts and address documentation issues promptly.

Beginning May 1, 2026, the Clinical Administrative LPN will conduct and document monthly audits of MARs to ensure medications and treatments are properly documented with date, time, and staff initials. Findings will be reported to Clinical Care Coordinator. Any deficiencies identified will be corrected immediately, and staff will receive additional education as needed. Audit documentation will be maintained for licensing review.

Licensee's Proposed Overall Completion Date: *05/01/2026*

Implemented ([redacted] - 05/11/2026)

187c - Refusal of Medication

7. Requirements

2600.

187.c. If a resident refuses to take a prescribed medication, the refusal shall be documented in the resident's record and on the medication record. The refusal shall be reported to the prescriber within 24 hours, unless otherwise instructed by the prescriber. Subsequent refusals to take a prescribed medication shall be reported as required by the prescriber.

Description of Violation

On 3/3/26 and 3/9/26 in the morning, Resident #1 refused a prescribed treatment of wound care Tx to left calf – cleanse with wound wash and cover with optifoam every three days and PRN for soiling/loosening until healed. The home did not report the refusals to the prescriber within 24 hours.

On 3/1/26, 3/2/26, 3/4/26, 3/5/26, and 3/13/26 in the morning and on 3/3/26 and 3/9/26 at bedtime, Resident #1 refused a prescribed dose of Biofreeze roll on gel 4% apply topically to right knee twice daily for right knee pain and advanced arthritis. The home did not report the refusals to the prescriber within 24 hours.

On 3/1/26, 3/5/26, 3/6/26, 3/8/26, 3/10/26, 3/12/26-3/15/26 and 3/17/26 at bedtime, Resident #1 refused a prescribed dose of Boost two times a day for dietary supplement. The home did not report the refusals to the prescriber within 24 hours.

On 3/1/26, 3/6/26, 3/9/26, 3/14/26, 3/15/26 in the morning and at midday, Resident #3 refused to take a prescribed dose of Ipratropium spray 0.03% blow nose to clear close opposite nostril instill - 2 sprays in each nostril 3 times daily. The home did not report the refusals to the prescriber within 24 hours.

187c - Refusal of Medication *(continued)*

Plan of Correction ***Accept ([redacted] - 04/17/2026)***

Per our policy, and in agreement with the Medical Director, resident refusals of non-critical medications are only reported after three consecutive days. This policy has now been updated to reflect all refusals must be reported to prescriber within 24 hours.
On March 18, 2026, nursing leadership reviewed medication and treatment refusal documentation for Residents #1 and #3. The prescribing providers were notified of the identified refusals at the monthly provider meeting on April 9, 2026. By April 30, 2026, staff will be re-educated regarding the requirement to notify the prescriber within 24 hours of any medication or treatment refusal unless otherwise directed. A review of resident care confirmed that residents were monitored appropriately and no adverse outcomes occurred as a result of the refusals.
By April 30, 2026, nursing and direct care staff will be re educated on the requirement to document all refusals on the MAR and in the resident record and to notify the prescriber within 24 hours unless otherwise instructed. Staff were provided clear guidance on escalation and documentation expectations for repeated refusals, including dietary supplements, topical treatments, and respiratory medications.
Beginning May 1, 2026, the Household Leads will conduct and document monthly audits of MARs and treatment records to ensure refusals are properly documented and prescriber notifications are completed within required timeframes. Any identified deficiencies will be addressed immediately through corrective action and staff reeducation. Audit records will be maintained for review during licensing inspections.

Licensee's Proposed Overall Completion Date: *05/01/2026*

Implemented ([redacted] - 05/11/2026)

187d - Follow Prescriber's Orders

8. Requirements

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident #1 is prescribed Cyclosporine emu 0.05% OP 1 drop both eyes twice daily. The resident was not administered this medication on the evening of 3/17/26 and the morning of 3/18/26 because the medication was not available.

Resident #6 is ordered checks to [redacted] once a week. Notify provider of any drainage increased tenderness, redness, or other concerns one time a day every Monday for monitoring to be completed by a nurse only. This check was completed on 3/9/26 by Staff Member A, who is not a nurse.

Plan of Correction ***Accept ([redacted] - 04/17/2026)***

On March 18, 2026, the Cyclosporine ophthalmic medication for Resident #1 arrived from the pharmacy after being delayed. It was obtained and made available, and administration resumed per the prescriber's order upon arrival of the medication. Nursing leadership reviewed the gap in administration and confirmed no adverse outcome occurred. Regarding Resident #6, nursing leadership immediately reviewed the monitoring order with staff. A licensed nurse evaluated the resident following identification of the concern to ensure the assessment was completed appropriately. No adverse findings were noted.
By April 30, 2026, the facility reinforced procedures requiring verification of medication availability to ensure all prescribed medications are administered as ordered without interruption. Staff were reeducated on timely medication reordering and follow up.

187d Follow Prescriber's Orders (continued)

Additionally, staff will be reeducated by April 30, 2026 on adhering strictly to prescriber directions, including limitations on which staff may perform nurse only assessments. Orders specifying "nurse only" are now reviewed during shift change to ensure appropriate assignment and completion by licensed nursing staff. By April 30, 2026, providers will be educated on notifying Clinical Care Coordinator of any order containing LPN only directions. Beginning May 1, 2026, the Clinical Administrative and Administrative LPNs will conduct and document monthly audits of medication administration records and treatment orders to verify medications are administered as prescribed and that assessments designated as nurse only are completed by licensed nursing staff. Results will be shared with Clinical Care Coordinator. Any issues identified will be addressed immediately with corrective action and staff reeducation. Audit documentation will be maintained for licensing review.

Licensee's Proposed Overall Completion Date: *05/01/2026*

Implemented ([redacted] - 05/11/2026)

225c - Additional Assessment

9. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
2. If the condition of the resident significantly changes prior to the annual assessment.

Description of Violation

Resident #2's assessment, dated [redacted] indicated the resident is independent when turning and positioning in bed. However, the resident utilizes a bedside enabler device. The resident's assessment has not been updated to include the resident's need in turning and positioning in bed.

Resident #7's assessment, dated [redacted], indicated that the resident cannot self administer medications and that medications are locked/secured in the med cart at all times. On 2/2/26, the physician provided an order for Resident #7 to self administer Simethicone 125MG chew 1 tab by mouth 4 times daily as needed for gas at meals and bedtime. Resident #7's assessment was not updated to reflect this change.

Resident #8 has a history of exit seeking behaviors and elopement. However, Resident #8's assessment, dated 8/15/25, has not been updated to reflect the resident's behavior(s).

Plan of Correction ***Accept ([redacted] - 04/17/2026)***

On March 19, 2026, nursing leadership reviewed the assessments for Residents #2, #7, and #8. Each assessment was updated to accurately reflect the resident's current condition, functional needs, and behaviors. Updates included Resident #2's use of a bedside enabler device (resident no longer resides in the PCH), Resident #7's ability to self administer specific medication per physician order, and Resident #8's history of exit seeking behaviors. Resident care plans were reviewed and adjusted as needed to align with the updated assessments. No resident harm occurred.
By April 30, 2026, staff will be educated on the facility reinforced assessment procedures requiring timely updates whenever a resident experiences a significant change in condition, functional status, behaviors, or medication self administration ability. Household Leads were reeducated on identifying qualifying changes that require an additional assessment and updating the resident record accordingly. Assessment review is now incorporated into care plan updates and physician order review processes.
Beginning May 1, 2026, the Clinical Care Coordinator will conduct and document monthly audits of resident assessments to ensure they accurately reflect current resident conditions, behaviors, and care needs. Any identified

225c - Additional Assessment (continued)

gaps will be corrected immediately, and staff will receive additional education as necessary. Audit records will be maintained for review during licensing inspections.

Licensee's Proposed Overall Completion Date: *05/01/2026*

Implemented (- 05/11/2026)

233c - Key-Locking Devices

10. Requirements

2600.
233.c. If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

Description of Violation

Persons in the Secured Dementia Care Unit who do not have an identified need to be in a secured unit, including visitors, are unable to exit the SDCU on their own and at will.

Plan of Correction ***Accept (- 04/17/2026)***

Current procedure was reviewed and approved by DHS in prior inspections.
On March 18, 2026, the facility reviewed egress procedures within the Secured Dementia Care Unit. Personal Care IDT, Director of Facilities and Campus Safety manager met to discuss function of locking door system. Currently waiting on additional information from door company to make next steps on the plan.
Staff were reminded to ensure that visitors and other individuals without an identified need to remain in the secured unit are informed of exit procedures upon entry. This is being relayed currently by posted signs directing visitors to ask for assistance leaving or by requesting a fob to use on the doors until the keypads are installed. No adverse events occurred.
By April 30, 2026, Staff will be re educated on providing communication to visitors and other authorized individuals entering the Secured Dementia Care Unit, including how to exit the unit safely and independently when appropriate. Supervisory staff were instructed to verify compliance during routine rounds.
Estimated date for new keypad installation is June 15, 2026 or earlier based on vendor availability of parts and vendor ability to install. Upon installation of keypads, the code will posted conspicuously nearby the keypads for visitors to use to exit. Once the new keypads are installed, the Director of Personal Care will conduct and document monthly environmental safety checks of the Secured Dementia Care Unit to ensure exit instructions remain posted, visible, and accurate. Any deficiencies identified will be corrected immediately. Logs will be retained for review during licensing inspections.

Licensee's Proposed Overall Completion Date: *06/15/2026*

Implemented (- 05/11/2026)